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	AL11965370	**05/29/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE ALTAMONTE SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **360 MONTGOMERY ROAD** **ALTAMONTE SPRINGS, FL 32714**	

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0000 - Initial Comments

A Change of Ownership (CHOW) survey conducted on . Brookdale Altamonte Springs license # 9786 had deficiencies found at the time of the visit.

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the facility failed to ensure the Medication Observation Record (MOR) was accurate and up-to-date for 1 of 2 sample residents (#5).

Findings:

On at 10:45 AM, resident #5 reported that she "often runs out" of medications. She further explained that she prefers to get her medications from the local pharmacy and goes out to pick them up herself. She stated the staff do not tell her to reorder until there is no more medication, then she said she has to call the pharmacy to get the refill and go pick it up..

Review of the record for resident #5 revealed she was admitted on . Her health assessment, dated , documented diagnoses that included , , , , legally and . The 1823 documented the resident did not require assistance with medications.

Review of the MOR for , 2018 found the facility used an electronic record keeping software. There was a legend for the codes documented on each date for each medication. Code 09 stated "other/see nurses notes." Review of the nurses' notes provided for resident #5 for , and , found a large number of "code 9" entries were explained with the letters "na" for documented "meds not available" or "no meds." There were instances when code 09 was used and the nurses note documented the resident "refused" (which would have been code 02).

, tablet delayed release, 20mg; 1 tablet one time per day; written . Code 09 was documented on 5/7, . Nurses notes documented "not available" on & . There was no explanation for the code on 5/7.

-S tablet 8.6-50mg, give 2 tablets once daily. Code 09 was documented on 5/3, 5/4, 5/5, 5/7- , - . The medication was documented as being given in , 2018 on the 1st, 6th & 21st. There was no documentation or explanation on 5/2- that date was left blank. Nurses notes documented by code 09 indicated "refused" on 5/8 and "not available" on the other 23 dates showing code 09. On at 2:55PM, the Director of Nursing stated the prescription, written on , was never

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picked up by the resident or the facility. She did not have an explanation as to why it was marked as given or refused on several dates.

On [redacted] at 2:55 PM the Director of Nursing (DON) stated resident #5 did prefer to use a local pharmacy, but the facility called the pharmacy to refill prescriptions for resident #5. She stated the staff alerted the resident "several days in advance, and repeatedly" when a medication supply was getting low. The DON stated, the resident often "does not feel like going out to get her prescriptions when they are ready- for many days in a row." When asked what the facility has done to ensure the resident gets her medications, she stated they had "sometimes" gone to get the medication for her, and they had been trying to get the resident to agree to use the pharmacy they have that delivers the prescriptions to the facility. After reviewing the nurses' notes the DON had printed for the [redacted], and [redacted], 2018 MORs for resident #5, she stated it appeared the staff were not using the notes correctly and were not always careful to use the correct code when the resident refused a medication or when the medication was not available in the facility.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on resident record review, Medication Observation Record (MOR) review and interview, the facility failed to ensure medications were reordered in a timely manner for 1 of 2 sampled residents (#5).

Findings:

On [redacted] at 10:45 AM, resident #5 reported that she "often runs out" of medications. She further explained that she prefers to get her medications from the local pharmacy and goes out to pick them up herself. She stated the staff do not tell her to reorder until there is no more medication, then she said she has to call the pharmacy to get the refill and go pick it up. The resident confirmed that she does get assistance with self-administration of medications and the facility did keep her medications locked and brought them to her when it was time for her doses.

Review of the record for resident #5 revealed she was admitted on [redacted]. Her health assessment, dated [redacted], documented diagnoses that included [redacted], legally [redacted]. The 1823 documented the resident did not require assistance with medications.

Review of the MOR for [redacted], 2018 found the facility used an electronic record keeping software. There was a legend for the codes documented on each date for each medication. Code 09 stated "other/see

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nurses notes." Review of the nurses' notes provided for resident #5 for , and , found a large number of "code 9" entries were explained with the letters "na" or documented "meds not available" or "no meds." There were instances when code 09 was used and the nurse's note documented the resident "refused" (which would have been code 02).

-S tablet 8.6-50mg, give 2 tablets once daily, order written on . Code 09 was documented on 24 dates in , 2018: 5/3, 5/4, 5/5, 5/7- , - . The medication was marked as being given in , 2018 on the 1st, 6th & 21st. There was no documentation or explanation on 5/2- which date was left blank. Nurse's notes documented by code 09 indicated "refused" on 5/8 and "not available" on the other 23 dates showing code 09.

On at 2:55PM, the Director of Nursing (DON) confirmed they did assist resident #5 with self-administration of her medications and they did centrally store the medications for the resident. She stated resident #5 preferred to use a local pharmacy, but the facility called the pharmacy to refill prescriptions for resident #5. She stated the staff alerted the resident "several days in advance and repeatedly" when a medication supply was getting low. The DON stated, the resident often "does not feel like going out to get her prescriptions when they are ready- for many days in a row." When asked what the facility has done to ensure the resident gets her medications, she stated they had "sometimes" gone to get the medication for her, and they had been trying to get the resident to agree to use the pharmacy they have that delivers the prescriptions to the facility.

The DON stated the resident or the facility never picked up the prescription, written on . She did not have an explanation as to why it was marked as given or refused on several dates.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on observations and interviews the facility did not provide or arrange for 3 of 4 sampled staff (A, B and D) to receive the mandated in-services training.

Findings:

1. Personnel record review for staff A hired 11/ as a dietary aide and the position changed to resident care aide in . The review revealed a certificate dated that indicated 1 hour (hr.) on the job resident care and ADLs. There was no evidence to confirm the staff received a 3 hours of in-service training on providing the following: 1. Resident behavior and needs. 2. Providing assistance

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with the activities of daily living. There was no evidence she was a Certified Nursing Assistant (CNA), Home Health Aide (HHA) or a licensed nurse, therefore except from the training

There was no evidence to confirm she received a 1 hr. in-service training regarding the facility's resident elopement response policies and procedures and 1. Reporting major incidents. 2. Reporting adverse incidents.

The continued review revealed a certificate for 26 minute Internet in-service dated regarding fire safety/fire sense. Another certificate dated indicated Disaster awareness. There was no evidence to confirm the staff received an in-service training regarding the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

2. Personnel record review for staff D, hired revealed an Internet certificate dated that indicated 61 minutes of training regarding elopement. The certificate agenda indicated safety sense and the risk of elopement in residents with . There was no evidence he received an in-service training regarding the facility's resident elopement response policies and procedures.

The review revealed an Internet certificate dated that indicated fire safety /sense. There was evidence to confirm he received a 1 hr. in-service training regarding the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation and 1. Reporting major incidents. 2. Reporting adverse incidents.

In an interview on at 3 PM, the business office manager said she was not aware that the in-service had to be specific to the facility's emergency procedure, since corporate approved the in-service. She was unable to locate certificates for staff A.

3. Personnel record review for staff B a caregiver hired revealed there was a certificate for a 70 minute training regarding resident behavior and needs and providing assistance with the activities of daily living, 3 hours of in-service training was required.

On at 3 PM, the business office manager confirmed the findings.

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Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on observations and interviews the facility did not provide or arrange for 1 of 4 sampled staff (A) to attend /received one-time education course on and .

Findings:

Personnel record review for staff A hired 11/ revealed no evidence to confirm she received a one-time education course on and . There was no evidence to confirm she was a licensed nurse, therefore except from this requirement.

In an interview on at 3 PM, the business office manager said she was unable to locate a certificate for staff A.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview and the facility failed to ensure 1 of 4 sampled staff (A) received at least one hour of training in the facility's policies' and procedures regarding ( ).

Findings:

Personnel record review for staff A hired 11/ revealed no evidence to confirm the staff received one hour of training in the facility's policies and procedures regarding .

Personnel record review for staff D, hired revealed an Internet certificate dated that indicated a 40 minutes of training regarding first aid and . There no evidence to confirm the staff received one hour of training in the facility's policies and procedures regarding .

In an interview on at 3 PM, the business office manager said she was not aware that the in-service had to be specific to the facility's policies and procedures, since corporate approved the in-service. She was unable to locate a certificate for staff A.

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0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on personnel record review and interview the facility failed to ensure staff had certificates that included the required information for 2 of 4 sampled staff (B and C).

Findings:

1. Personnel record review for staff B hired revealed there were certificates for the following training's that only had the facility's name and address stamped on them, the spaces for the trainer's name and signatures were left blank for elopement dated , Emergency procedures and incident reporting dated , resident rights dated and dated .

2. Personnel record review for staff C hired as a dining staff and position changed to care giver on revealed there were certificates for the following training's that only had the facility's name stamped on them, the spaces for the trainer's name and signatures were left blank for elopement and control both were dated .

On at 3 PM, the business office manager said the staff would take the training online and she would stamp the certificate after completion. She was not aware a signature was required.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on personnel record review and interview, the facility licensed with a capacity of 17 or more residents, did not have evidence that a job description was provided to 2 of 4 sampled staff (A and C).

Findings:

1. Personnel record review for staff C hired as a dining staff and position changed to caregiver on revealed there was no job description available for review.

On at 3 PM, the business office manager confirmed the findings.

2. Personnel record review for staff A hired 11/ as a dietary aide and the position changed to

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resident care aide on . The review revealed a dietary aide job description. Continued review revealed no evidence to confirm the staff was given a resident care aide job description.

Class

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on personnel record review and interviews the facility intentionally altered the personnel records for 4 of 4 sampled staff (A, B, C and D) in an attempt to deceive the Agency to appear in compliance with statutory requirements.

Findings:

1. Personnel record review for staff A revealed a statement dated that indicated a ( ) test was administered on at 4:15 PM and read at 10 AM and was non - reactive (negative). A Licensed Practical Nurse (LPN) read the test. The statement also contained the lot number and expiration of the vial.

Continued review revealed another statement that looked similar to the one dated , however the year was changed from 2016 to 2018 and was visible that the year had been erased and written over. The document indicated a test was done on at 4:15 PM and read at 10 AM and was signed by the same LPN. The lot number of the vial was the same as the vial used on 2016. The statement indicated the staff was found to have no indication of any condition, which may pose a hazard to the health of residents and associates in the community and was dated and the signature was a number one (1). The statements did not contain the healthcare provider's name, license, address and phone number.

2. Personnel record review for staff D revealed a freedom from statement dated that indicated negative for . The statement indicated to have the test read on after 4:40 PM or before 4:30 PM. The statement contained the signature of staff D and another signature but no credentials. On at 2, PM Staff D confirmed his signature.

Another statement dated , looked just like the one dated . The clinic's encounter number was the same as on . The dates were erased and written to indicate the test and the results were done in , 2017. The signature of staff D was different from the signature on 8/8 and . The statement indicated the staff was found to have no indication of any condition, which may pose a hazard to the health of residents and associates in the community and was dated and there was

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a signature but no credentials. The forms were from a local walk- in clinic.

In an interview with the business office manager /Human Recourses who said, she changed the forms as a reminder to herself as to when the test would be needed the next year. The half- sheet test result was pasted to a facility form "Associate Health Examination" and change the dates. These forms were kept

3. Personnel record review for staff B, a caregiver hired revealed there was a statement from a walk-in clinic that was on a half sheet in her record as documentation of freedom from ( ) form dated , the statement had a signature of the person reviewing the results that were not legible and there was no title.

Further review of the personnel record revealed there was a copy the same statement (half sheet) that was copied onto another form on with the name of Brookdale Altamonte Springs stamped on the top, the form noted on top "to be filled out by associate's physician", the form also had a space for the employees name and the position. Staff B name was in the space, her position was noted as care staff, and he/she appears to be free from communicable , including .

There was no signature space on this section of the form for the health care provider to sign. The two forms were copied together to make them look as if it was one form that was completed by the walk-in clinic.

4. Personnel record review for staff C who was rehired on as a dining staff and position changed to care giver on revealed there the was health care provider form on with the name of Brookdale Altamonte Springs stamped on the top. The form noted that on top "to be filled out by associate's physician". The form also had a space for the employees name and the position. Staff C's name was in the space and her position was noted as care staff and he/she appears to be free from communicable , including .

The next section of the form noted on at 11 AM, the form noted the staff had to return to have the result read between after 11 AM or before 11 AM. The test was administered and read on at 1:15 PM, the results were non-reactive and was read by a License Practical Nurse and on there was no signature but the office stamp of the walk-in clinic that included the health care providers name, license number address and telephone number.

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Further personnel record review for staff C revealed she resigned on and according to the business office manager she was rehired on .

There was a copy of the same form in the record. The date of the reading of the results and the date that was next to the health care providers stamp were both changed to . The date and time that the test was the same at 11 AM, the time that the results were read by the LPN was the same 1:15 PM. Everything on both forms were identical with the exception of the two dates that was evident that white out was used to change. This would mean the test was taken on and not read until .

On at 2:10 PM a telephone call was made to the walk-in clinic, the office manager was asked if their facility had completed this second form on that was identical to the first form that was completed on . The office manager reviewed her file and confirmed the form was completed on ; however, they did not complete another form on . She was provided the name of the LPN that had signed the form and she said that LPN did not work at the clinic on .

Regarding staff B form; she said when the clinic provided the employee the half sheet only it was because they did not bring the full sheet from the facility with them for the health care provider to complete. She said if they would have completed the full sheet, that form would have included the freedom from communicable statement, the health care provider's stamp would have been on the bottom of the form like the one that was completed for staff C on .

On at 2:25 PM the business office manager was asked about the discrepancies on Staff c' and b's forms. She reviewed the forms and said she would make a copy of the old health care providers form changed the dates on the form as a reminder to herself of when the next text was due. She replied that she guess it was a bad system that was not working.

The business office manager said for staff B she copied the half sheet from the walk-in clinic to the facility form that was used for freedom for communicable and added the employee's name because the walk-in clinic only sent back the half sheet.

The facility was asked to provide the personal records including proof freedom from including communicable . The personnel record were provided and the health care provider's statements were presented as evidence that the staff were in compliance.
In an attempt to deceive the agency, the facility provided fraudulent documentation for freedom from including communicable for the staff.

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The business office manager did not inform the agency staff prior to the review the records that she herself changed some of the test result dates as a "reminder" of when the next test were due. There were employee working at the facility who had fraudulently altered health care provider's statements, who may have not been tested within 30 days of hire or annually as required.

Class II

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on personnel record reviews, review of the online Agency background screening website, and interview, the facility failed to ensure 1 of 5 staff (C) who required a background screening, had a new background screening conducted following a break in employment of more than 90 days from a position that required screening.

Findings:

Personnel record review for staff C, a caregiver, revealed an eligible background screening that was dated on . Her personnel record revealed a resignation letter that noted her last date of employment would be .

On at 3:15 PM, the business office manager said staff C's employment ended on when she left the state of Florida. She was rehired at the facility on . This was more than a 90 break in employment.

A review of the online Agency background-screening website on at 3:30 PM revealed caregiver C did not have a new background screening since .

On at 4 PM, the administrator confirmed the findings.

Unclassified